TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Memorial Compounding Pharmacy

Respondent Name
Indemnity Insurance Company of North America

MFDR Tracking Number
M4-17-2463-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
April 14, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier has not paid or processed the bills/reconsiderations according to the timeframe per Texas Guidelines. We are now requesting Medical Fee Dispute Resolution."

Amount in Dispute: $436.78

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier is currently auditing the medical bill at issue in this dispute."

Response Submitted by: Downs-Stanford, P.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 6, 2016	Tramadol-Acetamenophen	$103.58	$0.00
July 6, 2016	Magnesium Oxide 400 mg	$61.85	$4.00
July 6, 2016	Cyclobenzaprine 5 mg	$104.75	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.240 sets out the procedures for payment or denial of a medical bill.
3. 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical services.
4. Submitted documentation did not include an explanation of benefits presented to the requestor prior to the request for medical fee dispute resolution.

Issues

Is Memorial Compounding Pharmacy (Memorial) entitled to additional reimbursement for the services in question?

Findings

Memorial is seeking reimbursement of $436.78 for the following drugs dispensed on July 6, 2016:

Drug	Amount
Tramadol-Acetaminophen	45
Magnesium Oxide 400 mg	30
Cyclobenzaprine 5 mg	30

Review of the submitted documentation does not support that an explanation of benefits was presented to Memorial to pay, reduce, or deny the services in question prior to the request for medical fee dispute resolution as required by 28 Texas Administrative Code §133.240. Therefore, the division concludes that Memorial is eligible for reimbursement as follows.

28 Texas Administrative Code §134.503 applies to the compounds in dispute and states, in pertinent part:

(c) The insurance carrier shall reimburse the health care provider or pharmacy processing agent for prescription drugs the lesser of:
  (1) the fee established by the following formulas based on the average wholesale price (AWP) as reported by a nationally recognized pharmaceutical price guide or other publication of pharmaceutical pricing data in effect on the day the prescription drug is dispensed:
    (A) Generic drugs: ((AWP per unit) x (number of units) x 1.25) + $4.00 dispensing fee per prescription = reimbursement amount;
    (B) Brand name drugs: ((AWP per unit) x (number of units) x 1.09) + $4.00 dispensing fee per prescription = reimbursement amount;
    (C) When compounding, a single compounding fee of $15 per prescription shall be added to the calculated total for either paragraph (1)(A) or (B) of this subsection; or
  (2) notwithstanding §133.20(e)(1) of this title (relating to Medical Bill Submission by Health Care Provider), the amount billed to the insurance carrier by the:
    (A) health care provider; or
    (B) pharmacy processing agent only if the health care provider has not previously billed the insurance carrier for the prescription drug and the pharmacy processing agent is billing on behalf of the health care provider.

Each drug is listed below with its corresponding reimbursement amount as applicable.

Ingredient	NDC & Type	Price/ Unit	Total Units	AWP Formula §134.503(c)(1)	Billed Amt §134.503 (c)(2)	Lesser of (c)(1) and (c)(2)
Tramadol-Acetaminophen	53746061710 Generic	$1.024	45 tablets	($1.024 x 45 x 1.25) + $4.00 = $61.60	$103.58	$61.60
Magnesium Oxide 400 mg	60258017101 Generic	$0.145	30 tablets	($0.145 x 30 x 1.25) + $4.00 = $9.44	$61.85	$9.44
Cyclobenzaprine 5 mg	00603307828 Generic	$1.57488	30 tablets	($1.57488 x 30 x 1.25) + $4.00 = $63.06	$104.75	$63.06
					Total	$134.10

The total allowable is $134.10. Per submitted explanation dated May 5, 2017, Indemnity Insurance Company of North America reimbursed $130.10. An additional reimbursement of $4.00 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $4.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $4.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Laurie Garnes	September 1, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.